



CONTRACT AMENDMENT

DSHS CONTRACT NUMBER:

0513-64943

Amendment No. 02

This Contract Amendment is between the State of Washington Department of Social and Health Services (DSHS) and the Contractor identified below.

Program Contract Number

Contractor Contract Number

CONTRACTOR NAME Molina Healthcare of Washington, Inc.		CONTRACTOR doing business as (DBA)	
CONTRACTOR ADDRESS 21540 30th Dr. SE, Suite 400 PO Box 1469 Bothell, WA 98041		WASHINGTON UNIFORM BUSINESS IDENTIFIER (UBI) 600-546-648	DSHS INDEX NUMBER 24261
CONTRACTOR CONTACT Peggy Wanta	CONTRACTOR TELEPHONE (425) 869-3555 Ext:	CONTRACTOR FAX (425) 869-4397	CONTRACTOR E-MAIL ADDRESS peggyw@molinahealthcare.com
DSHS ADMINISTRATION Medical Assistance Administration		DSHS DIVISION Program Support	DSHS CONTRACT CODE 7000XC
DSHS CONTACT NAME AND TITLE Alison Robbins Contract Manager		DSHS CONTACT ADDRESS P O Box 45530 649 Woodland Square Loop SE Lacey, WA 98504	
DSHS CONTACT TELEPHONE (360) 725-1634 Ext:	DSHS CONTACT FAX (360) 753-7315		DSHS CONTACT E-MAIL ADDRESS robbiaa@dshs.wa.gov
IS THE CONTRACTOR A SUBRECIPIENT FOR PURPOSES OF THIS CONTRACT? No			CFDA NUMBERS
AMENDMENT START DATE 10/01/2005		CONTRACT END DATE 12/31/2005	
PRIOR MAXIMUM CONTRACT AMOUNT \$0.00	AMOUNT OF INCREASE OR DECREASE \$0.00		TOTAL MAXIMUM CONTRACT AMOUNT \$0.00
REASON FOR AMENDMENT; CHANGE OR CORRECT CHOOSE ONE:			
ATTACHMENTS. When the box below is marked with an X, the following Exhibits are attached and are incorporated into this Contract Amendment by reference: <input type="checkbox"/> Additional Exhibits (specify):			
This Contract Amendment, including all Exhibits and other documents incorporated by reference, contains all of the terms and conditions agreed upon by the parties as changes to the original Contract. No other understandings or representations, oral or otherwise, regarding the subject matter of this Contract Amendment shall be deemed to exist or bind the parties. All other terms and conditions of the original Contract remain in full force and effect. The parties signing below warrant that they have read and understand this Contract Amendment, and have authority to enter into this Contract Amendment.			
CONTRACTOR SIGNATURE Draft Copy		PRINTED NAME AND TITLE	
DATE SIGNED			
DSHS SIGNATURE Draft Copy		PRINTED NAME AND TITLE	
DATE SIGNED			

This Contract between the State of Washington Department of Social and Health Services (DSHS) and the Contractor is hereby amended as follows:

Section 1, Definitions, is replaced with the following, and includes those that apply to mental health services, as follows:

1. DEFINITIONS

The following definitions shall apply to this agreement.

- 1.1. **Action** means the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment of a service; or the failure to provide services or act in a timely manner as required herein (42 CFR 438.400(b)).
 - 1.1.1. For a rural area resident with only one Managed Care Organization (MCO), action means the denial of an enrollee's request to obtain services outside the network:
 - 1.1.1.1. From any other provider (in terms of training, experience, and specialization) not available within the network;
 - 1.1.1.2. From a provider not part of the network that is the main source of a service to the enrollee – provided that the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the network or does not meet the qualifications, the enrollee is given a choice of participating providers and is transitioned to a participating provider within 60 days;
 - 1.1.1.3. Because the only provider available does not provide the service because of moral or religious objections;
 - 1.1.1.4. Because the enrollee's provider determines that the enrollee needs related services that would subject the enrollee to unnecessary risk if received separately and not all related services are available within the network; or
 - 1.1.1.5. Because the department determines that, other circumstances warrant out-of-network treatment.
- 1.2. **Advance Directive** means a written instruction, such as a living will or durable power of attorney for health care, recognized under the laws of the state of Washington, relating to the provision of health care when an individual is incapacitated (chapter 71.32 RCW, WAC 388-501-0125, 42 CFR 438.6, 42 CFR 438.10, 42 CFR 422.128, and 42 CFR 489 Subpart I).
- 1.3. **Ancillary Services** means health services ordered by a provider including but not limited to, laboratory services, radiology services, and physical therapy.
- 1.4. **Appeal** means a request for review of an action (42 CFR 438.400(b)).
- 1.5. **Appeal Process** means the Contractor's procedures for reviewing an action.
- 1.6. **Central Contract Services** means the DSHS central headquarters contracting office, or successor section or office.

- 1.7. **Chemical Dependency Professional** means a person certified as a chemical dependency professional by the Washington State Department of Health under chapter 18.205 RCW.
- 1.8. **Chemical Dependency Treatment Service** means a discrete program of chemical dependency treatment offered by a service provider who has a certificate of approval from the Department of Social and Health Services as evidence the provider meets the standards of chapter 388-805 WAC.
- 1.9. **Cold Call Marketing** means any unsolicited personal contact by the Contractor with a potential enrollee or an enrollee with another contracted managed care organization for the purposes of marketing (42 CFR 438.104(a)).
- 1.10. **Community Mental Health Agency** (CMHA) means a state licensed facility providing mental health services.
- 1.11. **Contracts Administrator** means the manager or successor, of Central Contracts Services or successor section or office.
- 1.12. **Contractor** means the individual or entity performing services pursuant to this Contract and includes the Contractor's owners, officers, directors, partners, employees, and/or agents, unless otherwise stated in this agreement. For purposes of any permitted Subcontract, "Contractor" includes any Subcontractor and its owners, officers, directors, partners, employees and/or agents.
- 1.13. **Comparable Coverage** means an enrollee has other insurance that DSHS has determined provides a full scope of health care benefits.
- 1.14. **Continuity of Care** means the provision of continuous care for chronic or acute conditions through enrollee transitions in providers, service area and between Medicaid fee-for-service and the MCO in a manner that does not interrupt medically necessary care or jeopardize the enrollee's health.
- 1.15. **Coordination of Care** means the Contractor's mechanisms that ensure that the enrollee and providers have access to and take into consideration, all required information on the enrollee's conditions and treatments to ensure that the enrollee receives appropriate health care services.
- 1.16. **Covered Services** means medically necessary services, as set forth in Section 11, Schedule of Benefits, covered under the terms of this agreement.
- 1.17. **Debarment** means an action taken by a Federal official to exclude a person or business entity from participating in transactions involving certain federal funds.
- 1.18. **DSHS or the Department** means the State of Washington, Department of Social and Health Services and its employees and authorized agents.
- 1.19. **Dual Coverage** means an enrollee who is privately enrolled on any basis with the Contractor and simultaneously enrolled with the Contractor under WMIP.
- 1.20. **Dual Eligible** or dually eligible means clients who have been determined eligible for both Medicare and Medicaid services.
- 1.21. **Eligible Clients** means DSHS clients living in the service area who have been DSHS certified as eligible for WMIP, and eligible to enroll for services under the terms of this agreement, as described in Section 2.2.

- 1.22. **Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part (42 CFR 438.114(a)).
- 1.23. **Emergency Services** means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish the services and are needed to evaluate or stabilize an emergency medical condition (42 CFR 438.114(a)). Psychiatric inpatient services are excluded from this definition.
- 1.24. **Emergent Care for Mental Health** means services provided for a person, that, if not provided, would likely result in the need for crisis intervention or hospital evaluation due to concerns of potential danger to self, others, or grave disability according to RCW 71.05.
- 1.25. **Enrollee** means a Medicaid recipient who is currently enrolled in the WMIP.
- 1.26. **Family** means those the enrollee defines as family or those legally appointed or assigned to provide support to the enrollee, such as parents, foster parents, guardians, siblings, caregivers and significant others.
- 1.27. **Grievance** means an expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights (42 CFR 438.400(b)).
- 1.28. **Grievance Process** means the procedure for addressing enrollees' grievances.
- 1.29. **Grievance System** means the overall system that includes grievances and appeals handled by the Contractor and access to the DSHS fair hearing system (42 CFR 438.400).
- 1.30. **Health Care Professional** means a physician or any of the following, acting within their scope of practice; a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, pharmacist, certified respiratory therapy technician or Mental Health Professional (as defined in Section 1.33 of this agreement) (42 CFR 438.2).
- 1.31. **Managed Care** means a prepaid, comprehensive health care delivery system that includes preventive, primary, specialty and ancillary health services. For the purposes of this contract, Managed Care includes services described in Section 11 of this agreement.
- 1.32. **Marketing** means any communication from the Contractor to a potential enrollee that can be reasonably interpreted as intended to influence them to enroll with the Contractor (CFR 438.104(a)).
- 1.33. **Marketing Materials** means materials that are produced in any medium, by or on behalf of the Contractor, that can be reasonably interpreted as intended to market to potential enrollees or enrollees with another DSHS contracted managed care organization (42 CFR 438.104(a)).
- 1.34. **Medically Necessary Services** means services that are reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger

life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this definition, "course of treatment" may include mere observation, or, where appropriate, no treatment at all.

- 1.35. **Mental Health Care Provider (MHCP)** means the individual with primary responsibility for implementing an individual service plan for mental health rehabilitation services.
- 1.36. **Mental Health Professional** means:
- 1.36.1. A physician or osteopath licensed under chapter 18.57 or 18.71 RCW or is board eligible in psychiatry;
 - 1.36.2. A psychiatrist, psychologist, psychiatric nurse or social worker as defined in chapters 71.05 and 71.34 RCW;
 - 1.36.3. A person with a master's degree or further advanced degree in counseling or one of the social sciences from a accredited college or university. Such person shall have, in addition, at least two years of experience in direct treatment or persons with mental illness or emotional disturbance, such experience gained under the supervision of a Mental Health Professional;
 - 1.36.4. A person who meets the waiver criteria of RCW 71.24.260, which was granted prior to 1986;
 - 1.36.5. A person who has an approved exception to perform the duties of a Mental Health Professional that was requested by the regional support network and granted by the DSHS Mental Health Division prior to July 1, 2002; or
 - 1.36.6. A person who has been granted a time-limited waiver of the minimum requirements of a Mental Health Professional by the DSHS Mental Health Division consistent with WAC 388-865-0265.
- 1.37. **Mental Health Specialist** means a Mental Health Professional with additional training and experience in the areas of child, geriatric, ethnic minority or disability mental health services, as defined in chapter 388-865 WAC.
- 1.38. **Participating Provider** means a person, health care provider, practitioner, as defined in the Quality Improvement Program Standards, Exhibit A, or entity, acting within their scope of practice, with a written agreement with the Contractor to provide services to enrollees under the terms of this agreement.
- 1.39. **Peer Counselor** means an individual who: has self-identified as a consumer or survivor of mental health services; has received specialized training provided/contracted by DSHS; has passed a written/oral test, which includes both written and oral components of the training; has passed a Washington State background check; has been certified by the DSHS, Mental Health Division; and is registered as a counselor with the Washington Department of Health.
- 1.40. **Peer-Reviewed Medical Literature** means medical literature published in professional journals that submit articles for review by experts who are not part of the editorial staff. It does not include publications or supplements to publications primarily intended as marketing material for pharmaceutical, medical supplies, medical devices, health service providers, or insurance carriers.

- 1.41. **Personal Information** means information identifiable to any person, including, but not limited to, information that relates to a person's name, health, finances, education, business, use or receipt of governmental services or other activities, addresses, telephone numbers, Social Security Numbers, driver license numbers, other identifying numbers, and any financial identifiers.
- 1.42. **Physician Group** means a partnership, association, corporation, individual practice association, or other group that distributes income from the practice among its members. An individual practice association is a physician group only if it is composed of individual physicians and has no subcontracts with physician groups (42 CFR 434.70).
- 1.43. **Physician Incentive Plan** means any compensation arrangement between the Contractor and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services to enrollees under the terms of this agreement (42 CFR 434.70).
- 1.44. **Post-stabilization Services** means covered services, related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition or to improve or resolve the enrollee's condition (42 CFR 438.114 and 42 CFR 422.113(c)).
- 1.45. **Potential Enrollee** means a Medicaid recipient who may voluntarily enroll in WMIP but is not yet an enrollee. (42 CFR 438.10).
- 1.46. **Primary Care Provider (PCP)** means a participating provider who has the responsibility for supervising, coordinating, and providing primary health care to enrollees, initiating referrals for specialist care, and maintaining the continuity of enrollee care. PCPs include, but are not limited to Family Practitioners, General Practitioners, Internists, Physician Assistants (under the supervision of a physician), or Advanced Registered Nurse Practitioners (ARNP), as designated by the Contractor. The definition of primary care provider is inclusive of the definition of primary care physician in 42 CFR 400.203 and all federal requirements for primary care physicians will be applicable to primary care providers as the term is used in this agreement.
- 1.47. **RCW** means the Revised Code of Washington. All references in this agreement to RCW chapters or sections shall include any successor, amended, or replacement statute. Pertinent RCW chapters can be accessed at <http://slc.leg.wa.gov/>.
- 1.48. **Risk** means the possibility that a loss may be incurred because the cost of providing services may exceed the payments made for services (42 CFR 434.2). When applied to subcontractors, loss includes the loss of potential payments made as part of a physician incentive plan, as defined herein.
- 1.49. **Routine Care for Mental Health** means evaluation and mental health services provided to consumers on a regular basis. These services are intended to stabilize, sustain, and facilitate consumer recovery within his or her living situation and are provided within fourteen (14) calendar days of the request for services.
- 1.50. **Service Area** means Snohomish County, Washington.
- 1.51. **Subcontract** means any separate written agreement or contract between the Contractor and an individual or entity ("Subcontractor"), or between a subcontractor and another subcontractor, to perform all or a portion of the duties and obligations the Contractor is obligated to perform pursuant to this agreement.
- 1.52. **WAC** means the Washington Administrative Code. All references in this Contract to WAC chapters or sections shall include any successor, amended, or replacement regulation. Pertinent WAC chapters or sections can be accessed at <http://slc.leg.wa.gov/>.

Section 3. ENROLLMENT:

2.7 Enrollment Listing and Requirements for Contractor's Response is amended to comply with HIPAA requirements as follows:

- 2.7.1 Before the end of each month, DSHS will provide the Contractor with a data file with the information needed to perform the health care services described in the Contract for managed care enrollees;
- 2.7.2 The data file will be in the Health Insurance Portability and Accountability Act (HIPAA) compliant 834 Benefit Enrollment and Maintenance format.
 - 2.7.2.1 The data file will be transferred from the DSHS Medicaid Management Information System (MMIS) to the Contractor using the DSHS, Department of Information (DIS) System ValiCert Secure File Transfer (SFT) system.
 - 2.7.2.1.1 The ValiCert SFT system uses 128 bit encryption Secure Socket Layer (SSL) to encrypt the file in transit (upload and download) and while stored on the SFT server.
 - 2.7.2.1.2 Access to the ValiCert SFT system site/folder is controlled by user Login ID and hardened password issued by DIS, through DSHS to the Contractor.
 - 2.7.2.2 The data file, in the 834 benefit enrollment and maintenance format, will list the enrollees whose enrollment is terminated by the end of that month, and the enrollees for the following month with the Contractor.
 - 2.7.2.3 The data file will include but not be limited to the following enrollee personal information: Name, address, SSN, age/sex, ethnicity, race and language markers.

Section 3. PAYMENT is amended to add the following two sections:

- 3.11. Risk Adjustment:** The DSHS-contracted actuaries will calculate risk scores for each individual enrollee, using the Chronic Illness and Disability Payment Systems (CDPS) methodology. However, the application of the CDPS risk score will be as a single composite factor applied to all Medicaid-only Disabled enrollees. The start-up risk factor will be set to 1.000. The factor will be revised quarterly thereafter, based on the most recent available enrollment information, and using twelve (12) months of claims data with at least six months of run out of claims. As WMIP membership stabilizes, the CDPS risk score may only be updated at six-month intervals. With each assessment, the composite risk score for all eligibles (those enrolled in WMIP and those eligible but remaining fee-for-service) will be normalized to achieve a compost of 1.000.
- 3.12. Mental Health Risk Adjustment:** The DSHS-contracted actuaries will calculate mental health risk scores for each individual enrollee, using parameters from the risk model developed by DSHS RDA. The risk model will be based on mental illness diagnoses and/or use of psychotropic medications. The application of the mental health risk score will be as a composite factor applied to all enrollees. The start-up risk factor will be set to 1.000. The factor will be revised quarterly thereafter, based on the most recent available enrollment information, and using twelve (12) months of claims data with at least six months of run out claims. As WMIP membership stabilizes, the risk score may only be updated at six-month intervals. With each assessment, the composite risk score for all eligibles (those enrolled in WMIP and those eligible but remaining in fee-for-service) will be normalized to achieve a compost of 1.000.
- 3.13. State-Only Funding:** DSHS shall pay the Contractor a maximum of \$13,000 per month for room and board costs associated with Evaluation and Treatment Centers, crisis beds, and basic supervision for residential beds. The Contractor shall track and report all expenditures in

accordance with Section 6.13, using these funds separately from expenditures made with Medicaid funds.

Section 4. ACCESS AND CAPACITY, is amended to address access standards for mental health services:

4.5 Utilization Management (UM):

- 4.5.1** Providers who make UM decisions must have education, training or professional experience in medical or clinical practice and either have a current license to practice or meet requirements for Mental Health Specialists or Chemical Dependency Professionals as necessary;
- 4.5.2** The Contractor shall use providers with appropriate qualifications to review denials based upon medical necessity, i.e., mental health specialists (mental health specialists are not required to be licensed but must meet requirements set forth in chapter 388-865 WAC), pharmacists, chemical dependency professionals, etc.;
- 4.5.3** The Contractor shall not structure compensation to individuals or entities that conduct utilization management activities so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.
- 4.5.4** The Contractor's utilization management activities must also include criteria for determining re-authorization of mental health services when previously authorized services have been exhausted, and guidelines for discharge from outpatient community mental health services.

4.6 24/7 Availability: The Contractor shall have the following services available on a 24-hour-a-day, seven-day-a-week basis. These services may be provided directly by the Contractor or may be delegated to subcontractors.

- 4.6.1** Medical advice for enrollees from licensed health care professionals concerning the emergent, urgent or routine nature of the enrollee's condition including the ability to connect with mental health crisis services when necessary.
- 4.6.2** Emergency Care;
- 4.6.3** Authorization of out-of-area urgent medical care;
- 4.6.4** Medically necessary mental health services. Emergent mental health care must occur within 2 hours of the request for mental health services from any source;

4.7 Urgent and Emergent Care for Mental Health Services: Enrollees may access urgent and emergent medically necessary mental health services (e.g. crisis mental health services, stabilization services) without completing intake evaluations and/or other screening and assessment processes. The Contractor shall ensure that timelines for accessing urgent and emergent services are met. Enrollees have access to following services prior to completing an intake evaluation:

- 4.7.1.1** Crisis Services;
- 4.7.1.2** Freestanding Evaluation and Treatment;
- 4.7.1.3** Stabilization;
- 4.7.1.4** Rehabilitation Case Management

4.8 Appointment Standards: The Contractor shall comply with appointment standards that are no longer than the following:

- 4.8.1** The Contractor shall ensure initiation of the initial mental health intake assessment by a Mental Health Professional within ten (10) working days of the request for mental health services. A request for mental health services can be made by telephone, referral, clinic walk-in or in writing.
- 4.8.2** Non-symptomatic (i.e., preventive care) office visits shall be available from the enrollee's PCP or an alternate provider within thirty (30) calendar days. A non-symptomatic office visit may include, but is not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or children and adult immunizations.
- 4.8.3** Non-urgent, symptomatic (i.e., routine care) office visit shall be available from the enrollee's PCP or an alternate provider within seven (7) calendar days. A non-urgent, symptomatic office visit is associated with the presentation of medical signs not requiring immediate attention.
- 4.8.4** Urgent, symptomatic office visits shall be available within 24 hours for medical or mental health services. An urgent, symptomatic visit is associated with the presentation of medical signs that require immediate attention, but are not life threatening.
- 4.8.5** Emergency care shall be available 24 hours per day, seven days per week.
- 4.8.6** Comprehensive chemical dependency assessment and treatment services shall be provided to injection drug users no later than 14 days after the services have been requested by the enrollee. If the enrollee cannot be placed in treatment within 14 days, interim services must be made available to the enrollee.

4.9 Provider Network - Distance Standards: is amended to add distance standards for mental health providers as follows:

4.9.5 Mental Health Service Sites

Urban: 1 within 10 miles for 90% of WMIP enrollees in the Contractor's service area.

Rural: 1 within 25 miles for 90% of WMIP enrollees in the Contractor's service area.

Section 5., QUALITY OF CARE, is amended to add mental health requirements:

5.9 Practice Guidelines: The Contractor shall adopt practice guidelines that meet the following requirements (42 CFR 438.6):

- 5.9.1** Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
- 5.9.2** Consider the needs of enrollees and support client and family involvement in care plans;
- 5.9.3** Are adopted in consultation with contracted health care professionals;
- 5.9.4** Are reviewed and updated periodically as appropriate;
- 5.9.5** Are disseminated to all affected providers and, upon request, to DSHS, enrollees and potential enrollees;

- 5.9.6 Are the basis for and are consistent with decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply;
- 5.9.7 Use the American Society of Addiction Medicine (ASAM) Guidelines for Chemical Dependency to determine appropriate levels of care for chemically dependent enrollees in accordance with chapter 388-805 WAC;
- 5.9.8 Must include at least two mental health-specific guidelines, including documentation of why the guidelines were adopted.

Language is added to Section 5.10.9 that directs the enrollee to file complaints with DSHS regarding Contractor non-compliance with advance directives for psychiatric care requirements:

- 5.10.9 The Contractor shall inform enrollees that they may file a grievance with the Contractor if the enrollee is dissatisfied with the Contractor's advance directive policy and procedure or the Contractor's administration of those policies and procedures. The Contractor shall also inform enrollees that they may file a grievance with DSHS if they believe the Contractor is non-compliant with advance directive requirements, and that the enrollee may file complaints concerning noncompliance with advance directives for psychiatric care requirements by contacting the DSHS, Mental Health Division's Quality Improvement and Assurance staff.

Section 6, REPORTING REQUIREMENTS is amended to add HEDIS requirements and reports for mental health measures:

- 6.2.3 The following HEDIS® measures will be collected during the course of this contract, submitted no later than June 15, 2007, and then by June 15 of each year thereafter, contingent upon this Contract begin extended through that period. The Contractor shall submit measures electronically to DSHS with a second copy to the EQRO designated by DSHS, using the NCQA-supplied data reporting tool:
 - 6.2.3.1 Breast Cancer Screening;
 - 6.2.3.2 Follow-up after Hospitalization for Mental Illness;
 - 6.2.3.3 Antidepressant Medication Management.

6.3 Reports on Screening, Access and Treatment for Chemical Dependency Issues is amended to add the following language:

- 6.3.4 These measures will be audited by MAA's External Quality Review Organization (EQRO) using the Validating Performance Measures protocols (CFR 438.356 (b)(2)) in 2006.

Section 6.4, Reports on Access and Maintenance for Mental Health Enrollees is a new section:

- 6.4.1 The Contractor shall report the number of WMIP enrollees who received outpatient mental health services using two separate reports: Report #1 details those enrollees who received follow-up mental health services within seven (7) calendar days of discharge from the State Hospital, Community Hospital, or Evaluation and Treatment Center.
 - 6.4.1.1 The Contractor shall collect data on this measure using the number of WMIP enrollees who were discharged from a State Hospital, Community Hospital, or Evaluation and Treatment (E & T) center from October 1, 2005 through June 30, 2006 and who received outpatient services within seven (7) calendar days after discharge.

6.4.1.2 To be included in the measure, the WMIP enrollee must have been discharged from October 1, 2005 through June 30, 2006. Outpatient services can occur beyond June 30, 2006 (i.e. a WMIP enrollee who was discharged on June 30, 2006 but did not receive outpatient services until July 7, 2006 would be included in the measure).

6.4.2 Report #2 details those enrollees who received follow-up mental health services within thirty (30) calendar days of discharge from the State Hospital, Community Hospital, or Evaluation and Treatment center and is inclusive of the services provided to enrollees within seven days of discharge.

6.4.2.1 The Contractor shall report the number of WMIP enrollees who were discharged from a State or Community Hospital, or Evaluation and Treatment center and who were readmitted to any inpatient settings within 30 days.

6.4.2.2 The Contractor shall collect data for this measure using the number of WMIP enrollees who were readmitted to a State or Community Hospital, or Evaluation and Treatment center within 30 calendar days of being discharged from these settings from October 1, 2005 through June 30, 2006.

6.4.2.3 To be included in the measure, the WMIP enrollee must have been discharged (as defined in Section 6.2.1.2) between October 1, 2005 and June 30, 2006, but the readmission can occur after June 30, 2006 (i.e. an enrollee who was discharged in June 25, 2006, and was readmitted July 1, 2006 would be included in the measure).

6.4.3 These measures will be audited by MAA's External Quality Review Organization (EQRO) using the Validating Performance Measures protocols (CFR 438.356 (b)(2)) in 2006.

Section 6, Reporting is also amended to add 6.13. Reporting on State-Only Expenditures:

6.13 Reporting on State-Only Expenditures: The Contractor shall report the state only expenditures to DSHS quarterly by the following categories: crisis bed expenses, E & T expenses, and residential expenses. The report is due fifteen (15) days after the end of each quarter (March, June, September, and December of each year).

Section 10.2 Critical Incident Reporting, is amended to include updated language:

10.2 Critical Incident Reporting: The Contractor shall notify DSHS of any critical incident as described below:

10.2.1 Examples of incidents to report include but are not limited to: homicide, attempted homicide, completed suicide, the unexpected death of a consumer, abuse or neglect of an enrollee by an employee or volunteer, loss of crisis lines, loss of service or residential sites.

10.2.2 Notification must be made to the Mental Health Services Chief or his/her designee during the business day in which the Contractor becomes aware of such an event. If the event occurs after business hours, notice must be given as soon as possible during the next business day.

10.2.3 Notification must include a description of the event, any actions taken in response to the incident, the purpose for which any action was taken, and any implications to the service delivery system.

10.2.4 When requested by DSHS, the Contractor shall submit a written report within two weeks of the original notification to provide information regarding efforts designed to prevent or lessen the possibility of future similar incidents.

Section 10.12.28 is amended as follows to add a requirement to provide enrollees with information about mental health providers:

- 10.12.28 Upon request by an enrollee, the Contractor shall provide information regarding Mental Health Care Providers (MHCPs) including: those who are not accepting new enrollees, and information regarding licensure, certification and accreditation status of MHCPs and MHPs.

Section 11.2 is amended to add requirements for mental health evaluations and individual treatment planning:

11.2 Care Coordination: The Contractor shall provide Care Coordination services that ensure access to and integration of preventive, primary, acute, post acute, outpatient mental health and chemical dependency into a well coordinated system. In addition to coordinating the services covered by the WMIP, the Contractor shall coordinate the services it provides to its enrollees with the services enrollees receive from other care systems.

11.2.1 The Contractor shall provide a Care Coordination system designed to:

11.2.1.1 Ensure communication and coordination of an enrollee's care across network provider types and settings; and

11.2.1.2 Ensure smooth transitions for enrollees who move among various care settings.

11.2.2 The Care Coordination system shall provide each enrollee with a primary contact person who will assist the enrollee in accessing services and information. The system shall promote and assure service accessibility, attention to individual needs, continuity of care, comprehensive and coordinated service delivery and culturally appropriate care. The Contractor shall designate a care coordinator and/or nurse practitioner to provide an initial screening and needs assessment that forms the basis for a comprehensive care plan, and for developing and implementing the care plan. The care coordination system shall be responsible for the following:

11.2.2.1 Provide an initial screening for all enrollees, to assign risk level and determine the enrollee's need for services. The initial screening shall take place within forty-five (45) days of enrollment. If the Contractor is unable to conduct the initial screening within 45 days, the Contractor shall document efforts to conduct the screening.

11.2.2.2 Provide a comprehensive assessment for clients who have been determined, by claims data, and/or through the initial screening, to be high risk, or who have been identified as having special health care needs by DSHS or through the screening process. Enrollees determined to have mental health needs will be provided access to an intake evaluation by a Mental Health Professional (MHP). The Contractor shall also ensure periodic (at a minimum of every 180 days) reassessment as necessary, of supports and services, based on the Enrollee's strengths, needs, choices and preferences for care.

The Contractor shall ensure that the assessment takes place within thirty (30) days of the initial screening. The assessment will include medical, social and environmental, mental health and chemical dependency factors and will determine whether the enrollee should be referred for specific services. The assessment will also identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring.

If the enrollee is determined to need services covered by this contract, the Contractor shall ensure coordination of the referral to the appropriate service. If the service is covered by DSHS on a fee for service basis, the Contractor shall coordinate with appropriate service providers to ensure the enrollee receives the needed service. The Contractor shall coordinate this assessment with required assessments done by DSHS staff. If the

Contractor is unable to conduct the screening, the Contractor shall document efforts to do so in the enrollee's file.

- 11.2.2.3 Develop a comprehensive care plan based on issues or needs identified by the initial assessment, medical records and/or prior utilization data to the extent they are available, enrollee and/or family input, PCP input if the enrollee has a PCP, along with other appropriate health care professionals the enrollee may be seeing. If the enrollee does not have a PCP, the Contractor shall assist the enrollee in finding one. The care plan shall incorporate an interdisciplinary/holistic and preventive focus, address any barriers to care, accommodate the specific cultural and linguistic needs of the enrollee, and include advance directive planning and enrollee participation. For enrollees who have been assessed to have mental health needs, the care plan must include treatment goals in the words of the enrollee, and the updates must include the enrollee's assessment of his or her progress towards meeting the goals. The Contractor shall ensure that the enrollee's plan is updated based on ongoing assessment or information received by a DSHS case manager or one of the enrollee's providers.
- 11.2.2.4 Have authority to approve referrals and request for services and equipment within the care plan:
- 11.2.2.5 Provide the enrollee with information about advance directives, and, assist the enrollee in advance directive planning, if the enrollee requests, based on enrollee needs and cultural considerations. The Contractor shall initiate discussion with the enrollee and/or the enrollee's family or guardian when the lack of a documented advance directive is identified through the assessment process. The advance directive or a record of the enrollee's refusal of assistance shall be kept on file in the enrollee's case management record.
- 11.2.2.6 Arrange and coordinate the provision of supports and services identified in the enrollee's care plan, including early intervention services and preventive care, skilled specialty services and, community-based services.
- 11.2.2.7 Assist the enrollee and his or her family or legal representatives, if any, to maximize informed choices of services and control over services and supports.
- 11.2.2.8 Monitor the enrollee's progress toward achieving the outcomes identified in the enrollee's care plan on a regular basis, in order to evaluate and adjust the timeliness and adequacy of services.
- 11.2.2.9 Coordinate with DSHS and local agency case managers, financial workers and other staff. This includes developing working agreements with DSHS, Division of Vocational Rehabilitation (DVR) local offices to coordinate supported employment activities for enrollees receiving mental health benefits.
- 11.2.2.10 Communicate on an ongoing basis, with the enrollee and with other individuals participating in the enrollee's care plan.
- 11.2.2.11 Educate and communicate with the enrollee about good health care practices and behaviors.
- 11.2.2.12 Have knowledge of basic enrollee protection requirements, including data privacy.
- 11.2.2.13 Inform, educate, and assist the enrollee in identifying available service providers and accessing needed resources and services, including those that are beyond the limitations of this agreement.

11.2.3 The Contractor shall develop written protocols for:

- 11.2.3.1 Tracking referrals;
- 11.2.3.2 Providing or arranging for second opinions, whether in or out of network;
- 11.2.3.3 Sharing clinic information with other entities serving the enrollee, including when appropriate, the results of the contractor's identification and assessment of enrollees with special health care needs, so that services provided to enrollees will not be duplicated.
- 11.2.3.4 Tracking and coordination of enrollee transfers from one setting to another (for example, hospital to home and nursing home to adult day health) and ensuring continuity of care.
- 11.2.3.5 Development of transition plans for enrollees when the enrollee is receiving services from a CMHA and the CMHA's contract with the Contractor is terminated for any reason.

11.2.4 The Contractor shall monitor continuity and coordination of care, using results of monitoring to improve continuity and coordination across the network. Monitoring activities shall include:

- 11.2.4.1 Annual collection of coordination data;
- 11.2.4.2 Identification of opportunities for improvement, using quantitative and causal analysis;
- 11.2.4.3 Selection of opportunities for improvement using coordination data.

Section 11.5 is amended to add inpatient and outpatient mental health services:

11.5 Mental Health Services – The Contractor shall provide inpatient and outpatient mental health services in accordance with RCW 70.02, 71.05, and 71.24 or any of their successors. The Contractor shall provide uninterrupted linkage through the range of covered services with the goal of moving the enrollee toward Resiliency and Recovery.

All Medicaid enrollees requesting covered mental health services must be offered an intake evaluation as defined in the Medicaid State Plan.

11.5.1 Outpatient Mental Health Services: The Contractor shall provide Outpatient Mental Health services to enrollees when they are determined to be medically necessary. Mental Health services must be directed towards helping the enrollee to live successfully in the community, must be culturally appropriate and be based on the initial assessment. Services are provided by or under the supervision of a Mental Health Professional.

The Contractor shall ensure a sufficient number, mix and geographic distribution of community mental health agencies (CMHA) and/or qualified personnel, including mental health care providers (MHCPs) to meet the requirements of this section and provide:

- 11.5.2.1 Access to an intake evaluation by a Mental Health Professional (MHP) within 10 days of the request for mental health services;
- 11.5.2.2 An age-appropriate and culturally appropriate range of medically necessary mental health services as described in this section.

11.5.2 The Contractor shall provide the following outpatient mental health services:

11.5.2.1 Brief Intervention: Solution focused and outcomes oriented cognitive and behavioral interventions intended to ameliorate symptoms, resolve situational disturbances which are

not amenable to resolution in a crisis service model of care and which do not require long term-treatment, to return the enrollee to previous higher levels of general functioning. Enrollees must be able to select and identify a focus for care that is consistent with time-limited, solution-focused or cognitive-behavioral model of treatment. Functional problems and/or needs identified in the enrollee's Individual Service Plan must include a specific time frame for completion of each identified goal. This service does not include ongoing care, maintenance/monitoring of the enrollee's current level of functioning and assistance with self/care or life skills training. Enrollees may move from Brief Intervention Treatment to longer term Individual Services at any time during the course of care. This service is provided by or under the supervision of a Mental Health Professional.

11.5.2.2 Crisis Services: Evaluation and treatment of enrollees who are experiencing a mental health crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, whose outcome decides whether possible bad consequences will follow. Crisis services shall be available on a 24-hour basis.

Crisis Services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the enrollee and in the least restrictive environment available. Crisis services may be provided prior to completion of an intake evaluation. Services are provided by or under the supervision of a mental health professional.

11.5.2.3 Day Support: An intensive rehabilitative program which provides a range of integrated and varied life skills training (e.g., health, hygiene, nutritional issues, money management, maintaining living arrangement, symptom management) for Medicaid enrollees to promote improved functioning or a restoration to a previous higher level of functioning. The program is designed to assist the individual in the acquisition of skills, retention of current functioning or improvement in the current level of functioning, appropriate socialization and adaptive coping skills. Eligible individuals must demonstrate restricted functioning as evidenced by an inability to provide for their instrumental activities of daily living. This modality may be provided as an adjunctive treatment or as a primary intervention. The staff to consumer ratio is no more than 1:20 and is provided by or under the supervision of a mental health professional in a location easily accessible to the client (e.g., community mental health agencies, clubhouses, community centers). This service is available 5 hours per day, 5 days per week.

11.5.2.4 Family Treatment: Psychological counseling provided for the direct benefit of the enrollee. Service is provided with family members and/or other relevant persons in attendance as active participants. Treatment shall be appropriate to the culture of the enrollee and his or her family and should reinforce the family structure, improve communication and awareness, enforce and reintegrate the family structure within the community, and reduce the family crisis/upheaval. The treatment will provide family-centered interventions to identify and address family dynamics and build competencies to strengthen family functioning in relationship to the consumer. Family treatment may take place without the enrollee present in the room but service must be for the benefit of attaining the goals identified for the enrollee in his or her individual service plan. This service is provided by or under the supervision of a mental health professional.

11.5.2.5 High Intensity Treatment: Intensive levels of services furnished under this contract, provided to enrollees who require a multi-disciplinary treatment team that is available 24 hour-per-day, seven-days-per-week, based on the enrollee's

need. Goals for High Intensity Treatment include the reinforcement of safety, promotion of stability and the independence of the enrollee in the community, and restoration to a higher level of functioning. These services are designed to rehabilitate enrollees who are experiencing severe symptoms in the community, and avoid more restrictive levels of care such as psychiatric inpatient hospitalization or residential placement.

The multi-disciplinary team consists of the enrollee, Mental Health Care Providers, under the supervision of a mental health professional, and other relevant persons as determined by the enrollee (e.g., family, guardian, friends and/or neighbors). Other community agency members may include probation/parole officers, teacher, minister, physician, chemical dependency counselor, etc. Team members work together to provide intensive coordinated and integrated treatment as described in the enrollee's individual service plan. The team's intensity varies among enrollee's and for each enrollee across time. The enrollee's symptoms and functioning will be continuously assessed by the team, allowing for the prompt implementation of needed modifications to the enrollee's individual service plan or crisis plan. Team members provide immediate feedback to the enrollee and to other team members. The staff to enrollee ratio for this service is no more than 1:15.

11.5.2.6 Group Treatment Services: Counseling in a group setting to assist the enrollee in meeting goals described in the ITP by learning from the experiences and perspective of others in the group. Services are provided to groups of 24 or fewer enrollees, with a staff to enrollee ratio of no more than 1:12. Group Treatment may include counseling and /or psychotherapy to help the enrollee establish and/or maintain stability in living, work and educational surroundings and should assist the enrollee to:

11.5.2.6.1 Develop self care and/or life skills;

11.5.2.6.2 Improve interpersonal skills;

11.5.2.6.3 Reduce results of traumatic experience and alleviate symptoms of mental illness.

11.5.2.7 Individual Treatment Services: Age and culturally appropriate services designed to assist individual enrollees to build strengths and maintain stability in daily life. Individual treatment services may include the enrollee's family and others the enrollee wants involved. Services provided may include: self-care/life skills training, counseling, psychotherapy and monitoring the enrollee's functional level. The Contractor shall ensure that Individual Treatment Services are provided at a location preferred by the enrollee.

11.5.2.8 Intake Evaluation: The Contractor shall ensure that an age and culturally appropriate evaluation takes place before delivery of any mental health service other than crisis services, stabilization and free-standing evaluation and treatment. The evaluation must take place within 10 working days of the request for evaluation and be completed within 30 working days and must be conducted by a Mental Health Professional. The purpose of the evaluation is to establish medical necessity for services; once medical necessity has been established, the Contractor may begin provision of services even if the intake evaluation has not yet been completed.

11.5.2.9 Medication Management: Is the prescribing, administering and review of medications and their side effects. The Contractor shall ensure that this service is provided by a provider licensed to provide medication management. Medication

Management may be provided in consultation with other providers, such as the enrollee's primary therapist and/or case manager, but includes only minimal psychotherapy.

11.5.2.10 Medication Monitoring: Face-to-face, one-on-one cueing, observing, and encouraging an enrollee to take medications as prescribed. Medication monitoring also includes reporting back to persons licensed to perform medication management services for the direct benefit of the enrollee. This service may take place at any location and for as long as it is clinically necessary. This service is designed to facilitate medication compliance and positive outcomes. Enrollees with low medication compliance history or persons newly on medication are most likely to receive this service. This service is provided by or under the supervision of a Mental Health Professional.

11.5.2.11 Peer Support: Peer Support is provided by peer counselors to enrollees under the consultation, facilitation or supervision of a Mental Health Professional who understands rehabilitation and recovery. This service provides scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Enrollees actively participate in decision-making and the operation of the programmatic supports.

11.5.2.11.1 Self-help support groups, telephone support lines, drop-in centers, and sharing the peer counselor's own life experiences related to mental illness will build alliances that enhance the consumer's ability to function in the community. These services may occur at locations where mental health consumers are known to gather (i.e., churches, parks, community centers, etc.). Drop-in centers are required to maintain a log documenting identification of the enrollee including Medicaid eligibility.

11.5.2.11.2 Services provided by peer counselors to enrollees are noted in the enrollee's ISP, which delineates specific goals that are flexible, tailored to the enrollee and attempt to utilize community and natural supports. Monthly progress notes document consumer progress relative to goals identified in the ISP and indicate where treatment goals have not yet been achieved.

11.5.2.11.3 Peer counselors are responsible for the implementation of peer support services. Peer counselors may serve on High Intensity Treatment Teams.

11.5.2.12 Psychological Assessment: Shall be provided by a licensed psychologist to assist the enrollee's provider in treatment planning. The psychological assessment includes all psychometric services provided for evaluations, diagnostic or therapeutic purposes by or under the supervision of a licensed psychologist.

11.5.2.13 Rehabilitation Case Management: Are activities conducted at or in coordination with, an inpatient facility to assist an enrollee in transitioning from an inpatient to a community setting. Rehabilitation Case Management activities include assessment for discharge, planning for integrated mental health treatment, resource identification, and linkage to mental health rehabilitation services, and collaborative development of individualized services that promote

continuity of care to enable the enrollee to stay in the least restrictive setting possible.

11.5.2.14 Special Population Evaluation: Age and culturally appropriate evaluation by a Mental Health Specialist (child, geriatric, disabled, or ethnic minority specialist) to gather enrollee-specific information to assist in treatment planning; the evaluation occurs after intake and is specific to one of the four Mental Health Specialist categories above.

11.5.2.15 Therapeutic Psychoeducation: Informational and experiential services designed to aid enrollees, their family members (e.g., spouse, parents), and other individuals identified by the individual as a primary natural support, in the management of psychiatric conditions, increased knowledge of mental illnesses and understanding the importance of their individual plan of care. These services are included in the Individual Service Plan and are provided at locations convenient to the enrollee, by or under the supervision of a mental health professional.

11.5.2.15.1 The primary goal of therapeutic Psychoeducation is to restore lost functioning and promote reintegration and recovery through knowledge of one's disease, the symptoms, precautions related to decompensation, understanding of the "triggers" of crisis, crisis planning, community resources, successful interrelations, medication action and interaction, etc. Training and shared information may include brain chemistry and functioning; latest research on mental illness causes and treatments; diagnostics; medication education and management; symptom management; behavior management; stress management; crisis management; improving daily living skills; independent living skills; problem solving skills; etc.

11.5.2.16 Mental Health Services provided in Residential Settings: A specialized form of rehabilitation service (non hospital/non IMD) that offers a sub-acute psychiatric management environment. Enrollees receiving this service present with severe impairment in psychosocial functioning or have apparent symptoms with unclear contributing factors due to their mental illness. Treatment cannot be safely provided in a less restrictive environment but the enrollee's symptoms do not meet hospital admission criteria. Individuals in this service require a different level of service than High Intensity Treatment. The Mental Health Care Provider is sited at the residential location (e.g., boarding homes, supported housing, cluster housing, SRO apartments) for extended hours to provide direct mental health care to the enrollee.

Therapeutic interventions both in individual and group format may include medication management and monitoring, stabilization, and cognitive and behavioral interventions designed to stabilize the enrollee and return him/her to more independent and less restrictive treatment. The treatment is not for the purpose of providing custodial care or respite for the family, nor is it for the sole purpose of increasing social activity or used as a substitute for other community-based resources. This service is billable on a daily rate. In order to bill the daily rate for associated costs for these services, a minimum of 8 hours of service must be provided. This service does not include the costs for room and board, custodial care, and medical services, and differs for other services in the terms of location and duration.

11.5.2.17 Freestanding Evaluation and Treatment means services provided in freestanding inpatient residential (non-hospital/non-IMD) facilities licensed by the Department of Health and certified by the Mental Health Division to provide medically necessary evaluation and treatment to enrollees who would otherwise meet hospital admission criteria. These are not-for-profit organizations. At a minimum, services include evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses and other mental health professionals, and discharge planning involving the individual, family and significant others so as to ensure continuity of mental health care. Nursing care includes but is not limited to: performing routine blood draws, monitoring vital signs, providing injections, administering medications, observing behaviors and presentation of symptoms of mental illness. Treatment modalities may include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology. The individual is discharged as soon as a less-restrictive plan for treatment can be safely implemented.

This service is provided for enrollees who pose an actual or imminent danger to self, others, or property due to a mental illness, or who have experienced a marked decline in their ability to care for self due to the onset or exacerbation of a psychiatric disorder. The severity of symptoms, intensity of treatment needs or lack of necessary supports for the individual does not allow them to be managed at a lesser level of care. This service does not include cost for room and board.

11.5.3 Inpatient Hospital Services: The Contractor shall cover inpatient mental health services for both voluntary and involuntary admissions in community settings and shall develop communications plans with contracted hospitals to ensure notification in the event that an enrollee is admitted for psychiatric evaluation and/or treatment.

11.5.4 Coordination with State Hospital re: Discharge and Planning

11.5.4.1 Respond to state hospital census alerts by working with hospital staff and community providers to ensure the availability of services using alternative community resources and other covered mental health services.

11.5.4.2 Ensure that contact with the state hospital occurs within three working for all enrollee admissions and provide the hospital with all available information regarding the enrollee's case, including intake documentation and case notes.

11.5.4.3 Implement mechanisms that promote rapid and successful reintegration of enrollees back into the community from the state hospital. The Contractor shall:

11.5.4.3.1 Designate a CMHP/CMHA with primary responsibility for coordination of the mental health aftercare services that the enrollee receives, based on medical necessity.

11.5.4.3.2 Provide the CMHP the information necessary for effective access to continuity of care for enrollees returning to the community, to promote successful community reintegration and recovery.

11.5.5 Court Ordered Services: The Contractor shall respond to requests for participation, implementation, and monitoring of enrollees in the provision of mental health outpatient services to enrollees who are:

11.5.5.1.1 On a Less Restrictive Alternative court order in accordance with RCW 71.05.320 and WAC 388-865-0466;

11.5.5.1.2 On a Conditional Release under RCW 72.05.340; or

11.5.5.1.3 On a Conditional Release under RCW 10.77.150.

11.5.6 1915(b)(3) Services: The Contractor shall ensure the following services are available through the WMIP, to eligible enrollees:

11.5.6.1 Respite Care: Services to sustain the primary caregivers of enrollees with mental illness. Respite care services may include providing observation, direct support and monitoring to meet the physical, emotional, social and mental health needs of an enrollee by someone other than the primary caregiver. Respite may be provided on a planned or emergent basis and may be provided in settings such as the enrollee's or caregiver's home, an organization's facilities, the respite worker's home or others. Respite care services must be flexible to ensure that the enrollee's daily routine is maintained. Respite care is provided by, or under the supervision of, a mental health professional. Enrollees who receive respite care services under another federal program are not eligible for those services under the WMIP.

11.5.6.2 Supported Employment: Services provided to enrollees who currently do not receive federally funded vocational services nor are on a waiting list for such services. Services are provided by or under the supervision of a mental health professional. Services include:

11.5.6.2.1 An assessment of work history, skills, training, education and person career goals;

11.5.6.2.2 Information about how employment will affect income and benefits the enrollee is receiving because of his or her disability;

11.5.6.2.3 Preparation skills such as resume development and interview skills;

11.5.6.2.4 Provide assistance to enrollees in developing and revising individualized job and career development plans that include the enrollee's:

11.5.6.2.4.1 Strengths and Abilities;

11.5.6.2.4.2 Preferences; and

11.5.6.2.4.3 Desired outcomes.

11.5.6.2.5 Assistance in locating employment opportunities that is consistent with the enrollee's strengths, abilities, preferences and desired outcomes;

11.5.6.2.6 Integrated supported employment, including outreach, job coaching and support in a normalized or integrated work site, if required (BY WHOM?);

11.5.6.3 Mental Health Clubhouse: The contractor shall provide clubhouse service for programs that use the International Center for Clubhouse Development (ICCD) standards as guidelines for program development. Clubhouse provides a mental health consumer-directed program to enrollees in which enrollees receive multiple services. Services may be provided through support groups, related meetings, consumer training, peer support and other similar services. Enrollees may drop in on a daily basis and participate in programs as they are able. Services include the following and are provided during evening and week-end hours as well as daily:

11.5.6.3.1 Work opportunities within the clubhouse that contribute to the operation and enhancement of the clubhouse community;

11.5.6.3.2 Opportunities to participate in administration, public relations, advocacy and evaluation of clubhouse effectiveness;

11.5.6.3.3 Assistance with employment opportunities, housing, transportation, education and benefits planning; and

11.5.6.3.4 Socialization activities.

The Contract is amended as follows to clarify the Contractor's and DSHS' roles in providing substance abuse treatment services to enrollees:

Section 11.6.2.2 is amended as follows: Alcohol/Drug detoxification services (acute and sub-acute) provided in a certified free-standing inpatient setting to provide care and treatment of enrollees while the enrollee recovers from the transitory effects of acute or chronic intoxication or withdrawal from alcohol or other drugs.

Section 11.7.2.4 is amended as follows: Residential substance abuse treatment services covered through the Division of Alcohol and substance Abuse (DASA).

All other terms and conditions of this Contract remain in full force and effect.